

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of \$889.23 for dates of service, 03/26/02 and 04/09/02.
- b. The request was received on 06/17/02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC 60 and Position Statement as stated on the Table of Disputed Services.
 - b. HCFA(s)
 - c. EOB/TWCC 62 forms/Medical Audit summary
 - d. Example EOBs from other insurance carriers
 - e. Prescription/Medical Necessity letter dated 02/05/02
 - f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
 - a. No response submitted
3. Per Rule 133.307 (g) (4), the Division forwarded a copy of the requestor's additional documentation to the carrier on 08/15/02. The Carrier's representative signed for their copy of the additional information on 08/16/02. The respondent did not respond to the additional documentation. The "No Response Submitted" sheet is reflected in Exhibit 2 of the Commission's case file.
4. Notice of Additional Information Submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: The requestor states in the Table of Disputed Services that, "We feel that we are due full and total Reimbursement's [sic] for the equipment we provided this patient with. We have billed the listed claims at a Fair & Reasonable rate. We have provided the carrier with addition [sic] documentational [sic] to support the cost of our billed charges. We are now requesting the remaining balance with Interest [sic]."

2. Respondent: No Position Statement submitted.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 03/26/02 and extending through 04/09/02.
2. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier \$1,694.00 for services rendered on the dates of service in dispute above.
3. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor \$804.77 for services rendered on the dates of service in dispute above.
4. The Carrier denied payment for dates of service commencing on 03/26/02 and extending through 04/09/02 as "M – NO MAR SET BY TWCC-REDUCED TO FAIR AND REASONABLE G – UNBUNDLING WATER CIRCULATING PAD—INCLUSIVE OF CODE E0236—F – FEE GUIDELINE MAR REDUCTION".
5. The amount in dispute is \$889.23 for services rendered on the dates of service in dispute above.
6. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MARS (Maximum Allowable Reimbursement)	REFERENCE	RATIONALE:
03/26/02	E0781 E1399 E0114	\$485.00 \$75.00 \$110.00	\$242.50 \$37.50 \$55.00	M for all codes	DOP	TWCC Act & Rules Sec. 413.011 (d), Rules 133.304 (i); MFG DME GR IX (C); MFG DME GR VIII	<p>The Carrier has denied the dates of disputed service, as "M-NO MAR SET BY THE TWCC-REDUCED TO FAIR AND REASONABLE".</p> <p>The provider has included in their dispute packet, documentation (EOBs from other carriers) that provides some evidence of "fair and reasonable" reimbursement.</p> <p>Since there is no MAR, the Medical Review Division has reviewed the file to determine which party has provided the most persuasive evidence as to whether the billed amount is fair and reasonable. The carrier did not respond to the dispute and, therefore, has not submitted any evidence or the methodology it used to determine fair and reasonable reimbursement. The provider has submitted EOB's that does show some evidence of fair and reasonable. Therefore, additional reimbursement is recommended in the amount of \$335.00</p>
03/26/02	E0236-NU	\$494.00	\$319.77	M	DOP	MFG GI VIII	<p>MFG GI VIII states "...NOTE: TWCC modifiers may differ from those published by the American Medical Association, and in submitting workers' compensation billing, only the modifiers set out in this Medical Fee Guideline shall be used..."</p> <p>This modifier is not recognized in the '96 MFG. For this reason, the Medical Review Division is unable to determine proper reimbursement.</p> <p>Since "NU" is an unrecognized modifier, no additional reimbursement is recommended.</p>
03/26/02	E1399	\$155.00	\$0.00	G	DOP	MFG DME GR	<p>According to the MFG DME GR, the water circulating pad is not global to the water pump, code E0236-NU.</p> <p>Therefore, reimbursement is recommended in the amount of \$155.00</p>
04/09/02	E0745	\$375.00	\$150.00	F	DOP	MFG DME IX (C)	<p>MFG DME GR states, "...Reimbursement shall be an amount pre-negotiated between the provider and carrier or if there is no pre-negotiated amount, the fair and reasonable rate. A fair and reasonable reimbursement shall be the same as the fees set for the "D" codes in the 1991 Medical Fee Guideline.</p> <p>There are no "D" codes listed in the MFG DME GR for E0745, neuromuscular stimulator.</p> <p>Therefore, reimbursement is recommended in the amount of \$225.00.</p>
Totals		\$1,694.00	\$804.77				The Requestor is entitled to reimbursement in the amount of \$715.00 .

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit **\$715.00** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 17th day of March 2003.

Pat DeVries
Medical Dispute Resolution Officer
Medical Review Division
PD/pd